

Questions About the April 7, 2000 Letter to State Medicaid Directors

Set #2

REINSTATEMENT

Question 24: How do HCFA's on-site reviews of State TANF/Medicaid/Section 4913 policies and procedures relate to the directives in this letter? Does this guidance summarize HCFA's findings? What is the time frame for the release of the State reports? Can a State wait until after HCFA releases its report to act?

Answer 24: We hope that the reports arising from our on-site reviews will be of assistance as States implement the April 7 guidance, and we are working to release draft reports as soon as possible. Since we are asking States to implement the guidance immediately, if a State has not received its draft report, it can arrange through its Regional Office to get a briefing on its review.

While we hope the reports are useful to States, HCFA's reviews were not the comprehensive State-wide examinations of enrollment policies and practices of the type envisioned by the April 7 letter. The reviews were limited to a point in time, and generally involved a review of some policy guidelines and other documents, a discussion with selected State officials and local caseworkers and managers in three local offices, and a review of a small sample of cases. A more thorough review of policies, practices, and computer systems is expected under the April 7 letter to determine whether improper terminations actually occurred. HCFA will make every effort to work with and provide technical assistance to States as they conduct their reviews and perform other activities as directed in the guidance.

Question 25: Will HCFA's reports identify improper actions on the part of States? Does a State need to conduct a complete investigation if HCFA's report identified few problems/concerns?

Answer 25: In some instances, the reports will cite and discuss issues of concern, including policies or practices that may have led to improper terminations. We believe the reviews were thorough but necessarily limited in scope. Therefore, even in instances where the report identifies few problems, we expect that each State will conduct its own review to determine if improper terminations occurred.

Question 26: What constitutes a "reasonably sufficient review" on the part of the State to identify

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improper actions that may have resulted in improper terminations? How far back should the State search? **Answer 26:** The components of a "reasonably sufficient review" will vary according to a State's organizational structure, operating procedures and practices, computer system, and other circumstances, so no one answer will cover all situations. As a general rule, we advise States to conduct a thorough State-wide examination of application, enrollment and termination policies

and practices since the implementation of its TANF program. In doing so, States should look for indicators of improper terminations. Some that have been identified by States include: a drop in enrollment in family and children's Medicaid since the implementation of welfare reform; evidence that welfare leavers are not receiving ongoing Medicaid coverage and/or are unaware of their potential continuing eligibility for Medicaid; the absence or recent adoption of a section 1931 policy; incorrect TANF sanction policy as it pertains to Medicaid and/or evidence of inappropriate application of TANF-related Medicaid sanctions; TANF termination notices that automatically link the TANF action with a Medicaid closure or that do not mention the potential of continuing eligibility for Medicaid; incorrect Transitional Medicaid (TMA) policy or evidence that eligible families did not receive TMA; evidence of automatic closure of Medicaid at the end of the TMA period without a proper redetermination including an ex parte review; variations of policy and procedure within the State that may result in improper implementation of State policies; and computer systems that automatically terminate beneficiaries unless manually overridden by staff.

These indicators can help States target their reviews. For example, if data indicates that a substantial portion of TANF leavers are not receiving Medicaid, a State can program its computer system to select all cases with TANF termination codes dating from the implementation of the TANF program and then review a statistically valid sample of cases closed under certain case closing codes to determine whether the terminations were proper or improper. Many States are identifying specific closing codes which might have been associated with improper termination.

Question 27: Does a State need to conduct an investigation if it already operates a Medicaid Eligibility Quality Control (MEQC) program?

Answer 27: All States should conduct comprehensive State-wide examinations of enrollment policies and practices, regardless of the status of their MEQC programs. However, the MEQC process may be helpful to States in this regard. Some States have relied on their MEQC process or their negative case review programs to identify problem areas and improper terminations. States may also find their corrective case action programs, along with their training programs, useful for the purposes of improving and streamlining redetermination procedures.

Question 28: Do all improper terminations necessarily result from improper actions, or can an improper termination result from a State's failure to take action? For example, if a State terminated a recently-closed TANF recipient from Medicaid because she failed to respond to a request due to a lack of information about her rights and responsibilities, was the termination improper?

Answer 28: Improper terminations can result from a failure by the State to take action, such as the

failure to conduct a Medicaid redetermination when terminating TANF or the failure to explain that the information solicited on a TANF redetermination form would be used to assess continuing eligibility for Medicaid. In the case of the above example, the termination would be improper if the State took action on Medicaid based on information requested solely for TANF purposes. Families may decide that they do not wish to continue receiving TANF but they may want to continue

receiving Medicaid. Without proper notice that information is needed to assess ongoing Medicaid eligibility, and the provision of information advising the family of the different rules and requirements relating to Medicaid, a family's failure to respond to a TANF request for information should not prompt a Medicaid closing, at least not without further contact with the family.

Question 29: Is the burden on the State to now find a recipient ineligible, as opposed to eligible, for assistance?

Answer 29: Under longstanding Federal regulation 42 CFR 435.930(b), States have a continuing obligation to provide Medicaid to all eligible persons until they have been properly determined ineligible for Medicaid. The intent of this regulation is to ensure that a State's redetermination process results in proper and efficient determinations. States and beneficiaries both have responsibilities in the redetermination process. States must explore all possible avenues of eligibility, rely on information that is reasonably available, and afford beneficiaries an opportunity to provide information necessary for the State to determine ongoing eligibility. If a beneficiary fails to provide necessary information or provides information that shows that he or she is no longer eligible for Medicaid, Medicaid coverage can be terminated. HCFA will continue to work with States to provide technical assistance and facilitate exchanges to promote best practices to improve and streamline redetermination procedures.

Question 30: If a State assigned a certain computer code to or manually handled Section 4913 cases, does it need to review them for improper terminations?

Answer 30: Yes. It appears that some children (Section 4913 children) who became ineligible for Supplemental Security Income (SSI) benefits due to a change in the SSI disability rules may have been terminated from Medicaid despite Congressionally mandated requirements. Working with HCFA, the Social Security Administration (SSA) has recently released to each State an updated State-only Disabled Children's File and a National Disabled Children's File, which identify Section 4913 children in that State and all States, respectively. Pursuant to our April 7 guidance, at minimum, States must promptly match the updated State-only file against their Medicaid rolls and determine which, if any, of those children are not currently receiving Medicaid or are receiving Medicaid but are not identified as a Section 4913 child. The match will identify whether children may have been improperly terminated and should be done even if a State believes it had an adequate procedure in place. States must report the results of the match to the HCFA Regional Office and reinstate children dropped from coverage. In addition, States can match the National Disabled Children's File against their Medicaid rolls to identify Section 4913 children who lost SSI in another State and, thus, would not appear on the State-only list. This will allow the State to identify Section 4913 children who apply for Medicaid after having been relocated from another State.

Question 31: What does "reinstatement" mean? Does it mean placing improperly terminated individuals back into the Medicaid category they should have been in at the time of the termination?

Answer 31: When States identify improperly-terminated individuals, they must reinstate them to the Medicaid category they were enrolled in at the time of the termination, with the exception of Section 4913 children who must be placed in the protected Section 4913 category. For example, an individual who was terminated improperly from Transitional Medicaid (TMA) should be reinstated to TMA. Furthermore, States must take steps, including the modification of computer systems, to ensure that all reinstated individuals remain eligible until the State has completed a proper redetermination of the individual's ongoing eligibility for Medicaid.

States have the option to identify and enroll eligible individuals who had applied for both TANF and Medicaid but who may have been denied Medicaid improperly because eligibility determinations continued to be linked. These individuals should be enrolled in the Medicaid category they were likely to have been eligible for, most likely Section 1931, at the time they filed an application.

Question 32: Would HCFA prefer that States with limited budgets identify, reinstate, and redetermine eligibility for affected individuals and families or invest their resources into initiatives such as continuous eligibility which extend health care coverage to more low-income children and families?

Answer 32: Over the past few years, States have made enormous progress increasing access to health care coverage for low-income children and families. Yet, instances in which eligible children and parents have lost out on coverage have come to light, and these problems have slowed down the Nation's progress toward lowering the numbers of uninsured individuals. All States must take steps to identify individuals who have been terminated improperly from Medicaid and reinstate them pursuant to Federal regulation 42 CFR 435.930, which established a continuing obligation to provide Medicaid to all eligible persons until they have been properly determined ineligible for Medicaid. Federal Financial Participation (FFP) will be available for up to 120 days of coverage after reinstatement (in some cases, it can be longer), pending a redetermination of ongoing eligibility, regardless of the outcome of the redetermination process. Efforts to ensure that children are not improperly terminated from Medicaid and the reinstatement of improperly terminated children and parents are required by law and will help States meet their child health enrollment goals. Initiatives, such as continuous eligibility, will also promote coverage. These initiatives are encouraged, but not required. HCFA will continue to collaborate with States to find cost-effective ways to provide health care coverage to more low-income children and parents through Medicaid or separate SCHIP programs.

Question 33: Can HCFA suggest methods of identification and reinstatement other than complete desk reviews or automatic reinstatement? Can a State simply reinstate those with certain termination codes?

Answer 33: States can analyze their own data and indicators of improper terminations, as described in Answer 26, in order to help identify improperly terminated individuals. State TANF, Medicaid, and

SCHIP enrollment data may provide indications of improper implementation of the welfare reform provisions that delinked cash assistance and Medicaid, particularly if, after taking State circumstances and activities into account, TANF-related Medicaid enrollment has decreased by much larger numbers than Medicaid-only enrollment for parents and children has increased. Quality control studies and TANF leaver studies may be helpful, and local data also may provide indications of improper eligibility and enrollment procedures, particularly if TANF, Medicaid, and SCHIP enrollment trends vary widely across localities, even after taking local circumstances into account. Analyzing procedures related to certain termination codes may be a particularly useful way to determine whether improper terminations have occurred. States may choose to reinstate categories of individuals as identified by termination code, rather than make specific findings that individual terminations were in fact improper.

Question 34: Will States have to review closures for other categories of Medicaid, like adult SSI, and reinstate any eligible individuals?

Answer 34: No. The April 7 guidance specifically requires States to identify and reinstate individuals or families who were improperly terminated from Medicaid due to the State's failure to adjust policies, systems, and procedures to conform with welfare reform laws that delinked cash assistance and Medicaid or with Section 4913 of the Balanced Budget Act of 1997 (BBA). However, States have a continuing obligation to provide Medicaid to all eligible persons who have not been properly determined ineligible for Medicaid. If States do identify other groups of beneficiaries who have been improperly terminated, reinstatement would be the proper action to take.

Question 35: How will HCFA react if States do not comply with this guidance? Will it sanction them?

Answer 35: HCFA is confident that States will implement this guidance and modify their eligibility processes and computer systems so as to prevent problems in the future and further streamline their programs. State organizations such as the National Governors Association (NGA) and the American Public Human Services Association (APHSA) have affirmatively stated that they agree that States should examine their policies and procedures and restore coverage to children and families who have been improperly terminated from Medicaid. Many States are already addressing the challenges associated with the delinkage of cash assistance and Medicaid, and have developed promising new strategies for ensuring that children and families who are not receiving cash assistance are properly evaluated for Medicaid. For example, Washington created the Family Medical Project to identify and reinstate individuals who lost Medicaid benefits when their TANF terminated. All States have recognized the importance of providing health coverage to children and families and have expanded eligibility, simplified enrollment procedures, and developed creative outreach campaigns to enroll additional eligible low-income children and parents in Medicaid and SCHIP.

In the event that a State fails to assure its computer systems do not improperly deny or terminate Medicaid coverage, fails to reinstate persons it has determined have been improperly terminated, or fails to conduct proper redeterminations, HCFA will consider whether compliance action should be taken under procedures set forth in Federal law and HCFA regulation.

Question 36: Does the State have the option to cover services provided to an individual or family after termination from Medicaid but before reinstatement?

Answer 36: Yes. States have the option to provide payment to individuals and providers for the cost of services covered under the State's Medicaid plan provided between the time the individual was terminated from Medicaid and reinstatement. FFP will be available to States that provide such retroactive payments, including direct payments by the State to individuals who had out-of-pocket costs for services that would have been covered by Medicaid had the individual not been terminated from the program. FFP in direct payments will be based on the full amount paid by that individual. FFP in payments to participating Medicaid providers will be at the Medicaid rate.

Question 37: Will the FFP rate be the current rate, or the rate in effect at the time of the improper termination?

Answer 37: Federal Financial Participation will be at the current rate.

Question 38: How do the provisions for Federal Financial Participation (FFP) described in the guidance differ from those found at Section 6320 of the State Medicaid Manual (SMM)?

Answer 38: The April 7 guidance states that FFP coverage for 120 days is available to all individuals and families who were improperly terminated as a consequence of the delinkage of cash assistance and Medicaid, whether or not they appealed the termination. States may, but are not required to, provide reimbursement to individuals and their providers for costs that would have been covered by Medicaid between the time the individual lost coverage and reinstatement. FFP in direct payments to individuals will be based on the full amount paid by that individual. FFP in payments to participating Medicaid providers will be at the Medicaid rate. As under regular Medicaid, FFP would not be available to the extent that third party reimbursement was available to pay for services.

In contrast to the April 7th letter, section 6320 of the SMM makes FFP available to individuals for direct reimbursement for corrective payment only if the services were paid for during the period between a denial of eligibility and a successful appeal of that denial and if third party reimbursement is not available. Under this provision of the SMM (in contrast to the April 7 guidance), payment is made according to the fee schedule specified in the State plan, even though the individual may have paid more than that amount.

Question 39: Do the FFP provisions in the April 7 letter, which provide for up to 120 days of coverage after reinstatement, apply to Section 4913 children?

Answer 39: Yes. FFP will be available for up to 120 days of coverage after reinstatement of a Section 4913 child, pending a redetermination of eligibility. In all cases of reinstatement, the State must attempt to redetermine eligibility on an ex parte basis. Once eligibility is determined, FFP will be available under the usual rules governing FFP in expenditures for Medicaid eligibles.

Question 40: Please explain the instruction: “If a State determines that there have been no instances of improper terminations, it should inform the Regional Office of the review undertaken and the basis for its conclusions.”

Answer 40: HCFA’s Regional Offices will work closely with States as they implement this guidance. If a State determines that there have been no instances of improper terminations, it should promptly inform its Regional Office contact of that conclusion. There is no prescribed form or format for doing so, but the State should completely and fully describe the process it followed in reaching its conclusion, including its review of data, its search for the indicators of improper terminations described in Answer 26, its State-wide examination of application, enrollment, and redetermination procedures, and its assessment of its computer-based eligibility systems.

Question 41: If a State determines that there have been improper terminations, does it need to report these findings to the Regional Office? Will HCFA share this information with other sources, including other Federal program offices? Will this information prompt additional investigations?

Answer 41: After conducting a comprehensive review to determine whether there have been improper terminations from Medicaid, a State should convey these findings to HCFA along with a plan and timetable for reinstating coverage, conducting follow-up eligibility reviews as appropriate, and modifying procedures and systems so as to prevent problems in the future. HCFA’s goal is to help States move forward to ensure that all eligible low-income individuals and families receive health care coverage through Medicaid or SCHIP. We will report to the Secretary on activities taken to address these problems and we will respond to particular requests for information, but we do not intend to release information about particular State activities except in response to specific requests to which we are obligated to respond. We do intend to share “best practices” across States and with other interested groups.

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